HIT Policy Committee

NHIN Workgroup

Wednesday, December 16, 2009, 10:00 a.m. to 1:00 p.m. Eastern
OMNI Shoreham Hotel, 2500 Calvert Street, NW, Washington, DC

Surescripts Testimony

Presented by Kathleen Mahan, Vice President of Product Management
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My name is Kathleen Mahan, and I am the Vice President of Product Management for Surescripts. As the Vice President of Product Management of the legacy SureScripts organization and now serving in a similar capacity for the new merged organization with RxHub, I have been involved in the development of an operational national health information exchange for prescription information now called Surescripts.

As most of you know, Surescripts is the Nation's E-Prescription Network which connects prescribers in all 50 states through their choice of e-prescribing software to the nation's leading payers, chain pharmacies and independent pharmacies. Through our work in standards, certification, education and collaboration at the national, regional and state levels, we have established a national digital healthcare infrastructure for the exchange of prescription information. Interoperability is at the core of our mission, focus and success.

I want to thank the HIT Policy Committee – NHIN Workgroup for the opportunity to comment on our experience in development and use of Directory Services. The Surescripts Directory Services support a national network that connects over 155,000 providers, over 52,000 community pharmacies, 6 mail order pharmacies and over 25 of the nations largest PBMs for the purposes of exchanging prescription related information in the ambulatory setting.

The Surescripts network success is grounded in a focus on neutrality, transparency and the use of industry standards. As a result, our network is now being utilized to support new interoperability use cases or requirements such as medication reconciliation processes within hospitals and the transmission of continuity of care record (CCR or

CCD) documents across the network to streamline documentation for transitions of care.

With that as a foundation, I will now turn to the specific questions of the committee.

What is the scope of service, content, structure, and business model of your directory services?

Surescripts' Directory Services consist of a Prescriber Directory and a Pharmacy Directory as well as the associated capabilities to create, update and share directory information across the network. Each directory contains a unique identifier for each participant on the network as well as demographic data, address information, certified application used, available services and more. The Directory Service offers two methods of update and maintenance: a messaging solution for automated updates; and, a web portal (Administrative Console) that can be securely accessed by all participants in the network assuming proper permissions. Surescripts assembles this information in Prescriber and Pharmacy Directory Download files that prescriber vendors and pharmacies / pharmacy vendors download to populate their end systems with the relevant data. Prescriber vendors pull the pharmacy download file and pharmacies / pharmacy vendors pull the prescriber download file.

Every prescriber on the network must be registered within the Surescripts Prescriber Directory. The identification of the prescriber and the entry of the necessary data is currently performed by the vendor using one of the methods described above. Upon completion and validation of the registration process, the prescriber is assigned a unique ID by location and by application. (Note that we are currently using an internally generated identifier, however an individual NPI that is clearly tied to the prescriber's location may be considered in the future.)

Similarly, each pharmacy on the network (i.e. chain, independent, specialty, mail order, etc.) must also be registered within the Surescripts Pharmacy Directory. This registration process is managed by the pharmacy organization or pharmacy vendor using one of the methods described above. The completed and validated registration record is assigned the industry standard NCPDP ID in this situation.

Currently, there is no charge to prescribing vendors for the three core Surescripts e-prescribing services: Prescription Benefit, Prescription History (ambulatory) and Prescription Routing. The Directory Services described above are included as part of the standard network services necessary to support these core e-prescribing services and they are covered in the standard business agreement for all network participants.

Retail Pharmacy, Mail Order Pharmacy and Pharmacy Benefit Management organizations pay a transaction based fee for participating in the network - no additional transaction fees are assessed for Directory messaging or downloads.

Based on your experience, how should directory services be governed and operated?

Within the Surescripts e-Prescription Network, Directory Services sit at the core of the network operations and should be governed with the mindset that these providers are sharing Protected Health Information. Whether faxed, mailed or electronically transmitted, the PHI is routed between the providers based on the provider's demographic and address information stored in a directories service.

Given that a network participant must go through different processes to obtain a DEA number, an NPI, and/or an NCPDP ID, it would be helpful if these processes were standardized and coordinated by the issuing entities in order to not duplicate efforts. In addition, the issuing entities should take into account and consider the requirements necessary to utilize this information for transaction routing and information exchange. For example, it is imperative that the directory service information be specific to the address where a patient received care; not where invoices are received. This is one of the most important challenges facing a national directory service as directory service offerings have traditionally focused on the flow of reimbursements; not sharing of patient information.

It should also be noted that alternative routes for electronic information may be necessary. As an example, if there is a communication failure in the network, it may be appropriate to fax a prescription to the pharmacy. In these situations, it is extremely important that fax numbers within the directories are accurate.

To have a truly successful directory offering, governance and operational maintenance should focus on the timely submission and updating of provider information where the provider (physician, physician's assistance, nurse practitioner, pharmacist, etc.) sees patients. While difficult, the directory service should impose some type of time limit as to when / how the directory information is made available to the provider either via staff (paper/fax) or via applications (electronic). A timely directory service is no good if the updated information sits days or weeks before being distributed to the end provider for use. We should learn from other distributed directory services such as LDAP and/or implementations such as DNS.

If your directories are currently used to facilitate information exchange as part of a proprietary network, could you imagine making your directory available as a service to other organizations? Could you imagine using a public directory instead of your internal one?

Surescripts currently makes our Directories Service available to all network participants. The Directory Service makes use of a web based XML messaging structure, which is an open source standard. Surescripts uses the syntax rules of XML and defines tags and field constraints to explicitly define what and how this information should be submitted.

The original design was intended for distribution to possibly all prescribers and pharmacies in the US and can likely be easily extended to the greater US healthcare system for implementation and use.

A public directory that addresses the following would be interesting to Surescripts:

1) Assurance of appropriate identity proofing;
2) Assignment of a single unique identifier that is location specific (based on where patient care is provided);
3) Assurance of timely submission and updates from providers;
4) Account for the distribution of directory information across the network in a real time manner
5) Indication of the level of service supported by the network participant (e.g. message types supported)

We believe that it would still be necessary for various networks to maintain their own directories for registration purposes, tracking of various service types by user, reporting, etc.

Is it feasible to aim for universal authoritative directories, or should we accept the reality of multiple, fragmented and overlapping directories?

We believe that it is reasonable to have both; however, the 'core' information should be standardized. Currently, it is unreasonable to think that all healthcare providers / systems will use the same directory data. Where one system may want additional data included in their provider directories, we believe there is a core set of data that can be standardized as a baseline for all providers for the purpose of sharing patient PHI. This data set includes:

1. Provider first name;
2. Provider last name;

3. Provider individual NPI – the NPI that was applied for by the individual. This should not be the entity type NPI;
4. Provider DEA – if provider possesses a DEA number, it should be provided;
5. Provider Address 1 (physical street address where patient was seen);
6. Provider Address 2 (suite, floor, etc.);
7. City, State, Zip – a valid USPS address;
8. Location Name – Clinic, Pharmacy, Lab, Hospital, etc.;
9. Enabled services – medications paper/electronic, eligibility paper/electronic, medication history, CCR/CCD documents, fax, paper, etc.

If possible, this minimum data set should be standardized through a recognized ANSI approved standard or through an open source standard (i.e. a type of XML).

If there were authoritative directories of providers, would other institutions (including vendors, health plans, and other organizations) integrate such directory services into their current or future business relationships?

Since most vendors, pharmacies, health plans, hospitals and other organizations already deal with the integration of provider information and the matching to their in house records, this integration, should it be required, would not take most by surprise. The challenge is that this is already a very time consuming and inefficient process even in the best of circumstances.

With the development of the NHIN, interoperability across health systems, provider groups, pharmacies, and health plans adds another layer of complexity. There are a variety of options for directories of provider information available today; however there are not specific standards that these directories must meet in order to ensure the accurate, complete and timely information that is necessary to easily integrate this information into various network services and end user applications.

The biggest challenge lies with presenting some type of incentive to the providers to make updates to a central authority. Currently, prescribers and pharmacies provide their information to several private directory types of services. The questions that we feel need to be answered are: What incentive would drive the individual provider to make updates whenever their information changed? How would these changes be distributed to private companies that make their revenue off this information? How could repetitive processes and conflicting information be avoided?

While a private business sector for directory files exists today, there is no silver bullet. These companies are all challenged with providing information on providers that can only be truly validated by the individual provider – their revenue streams depend on this. Individual providers are then challenged with which third party companies to maintain updated records as there are many.

What institutions could support these directory lists?

Organizations such as NCPDP / Ingenix and CAQH have a framework for updating of the "core" information that could then be effectively shared with other distributed directory services across the network. There are other organizations such as HMS, IMS, SK&A, etc. that provide a variety of data services that could also be incorporated into this structure.

We should also keep other data sources such as the AMA and the DEA in mind.

What will be required for these institutions to be trusted with the policy, technical, and administrative tasks? What are your views on the broader "trust fabric"?

Any institution that acts as an Authoritative Directory Service provider must meet a set of standards that address requirements including but not limited to the following:

1) Identity proofing / credentialing;
2) Core data requirements (i.e. NPI, DEA, demographics, etc.);
3) Validation processes for core data (i.e. DEA, NCPDP, NPI, etc.);
4) Frequency of update (e.g. bi-annually, quarterly, etc.);
5) Distribution services framework (e.g. file transfer, messaging, provider update, etc.);
6) Reporting;
7) Support infrastructure and processes to quickly resolve issues.

There could be a single authoritative provider for various directories such as physicians, pharmacies, hospitals, etc. or there could be a network of providers that are accredited to the Directory Services Provider standards.

We would suggest that the various distributed network directory services providers would then need to contract with the appropriate Authoritative Directory Service providers. Appropriate standards would need to be developed to ensure proper and timely directory synchronization across the network.

How might forms of credentialing and identity management be managed through directory services?

Credentialing is a natural extension of directory services. State licensing information and DEA numbers can be supplied to a directory authority but unless there is an explicit credentialing service, the information provided can be faulty. The information provided can be legitimate in the eyes of the provider but if they make an error, this information will be distributed to many end points subscribing to the directory authority for information.

To offer a complete service, an authority would have to retain real time services to check each state licensing authority, the DEA and other credentialing 'sources'.

Identity management in the forms of identity proofing and authentication are services that many private sector companies offer. Ideally the directory authority will make use of one said service. The solution must be able to initially identify an individual provider and, at a regularly scheduled interval, provide re-authentication services. Initial identification to establish the directory entry for a provider and validation of all information in the directory entry establishes the starting point for information that will then need to flow through the network.

It is possible that the Authoritative Directory Service could maintain other directory information such as public keys that can then be synchronized across the network.

What standards issues must be addressed to achieve more effective use of directory services?

NPI – the enumeration of the NPIs seems to be managed fairly well. We haven't seen many instances where duplicate NPIs have been issued. However, in order to be a truly effective NPI Distribution service; the entity needs to consider a systemic way to distribute the updates. If the NPI is showing signs of being relied upon as the de facto enumerator for providers, NPPES (or other?) needs to set up some type of message based update service with download options. Currently, the only way to access the file is by pulling the file off a website (not very automated). .

Entity type or Institutional DEAs work for billing purposes but do not work as identifiers when providers want to share data with each other. DEA Numbers should be used to

help uniquely identify a provider but should not be relied upon as a primary identifier (move to NPI) when comparing provider directory entries to each other.